PRINTED: 11/15/2021 FORM APPROVED

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. Bolebino.		С		
TN8901		B. WING		11/02/2021			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
NHC HEALTHCARE, MCMINNVILLE 928 OLD SMITHVILLE RD  MC MINNVILLE, TN 37110							
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)						
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	CORRECTIVE ACTION SHOULD BE COMPLETE REFERENCED TO THE APPROPRIATE DATE		
N 000	00 Initial Comments		N 000				
N 0000	Investigation of comp conducted on 11/2/20 McMinnville. No healt	laint #TN00055581 was 121 at NHC Healthcare, th deficiencies were cited 3-6, Standards for Nursing	N UUU				

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE